Advance Care Planning competencies

Advance Care Planning is a voluntary process of shared planning for future care. More information can be found on this website.

Basic Competency: what is it and who knows more

Staff this is applicable to: All staff who come into contact with patients or their families.

No	Units of competence	NOT MET	GETTING THERE	MET	My level
1	*Understand what ACP is in general terms*	Doesn't know what it is when asked	Has some idea what it is but could not explain it in general terms	Can explain that it is a process of thinking, talking and sharing what is important to a person and what future treatment and care they would want.	
2	*Explain in general terms what is it to patients and families who ask and what the benefits might be for patients*	Doesn't know what the benefits are	Knows what some benefits might be but unable to explain it	Can explain that the benefits of ACP are: (1) providing your family and healthcare team with important information about you and what you would like as you approach the end of life. (2) It improves decision-making, (3) reduces anxiety and depression for the person and their family, (4) it provides the person with greater control, (5) the person is more likely to get the care and treatment that they would have wanted.	
3	*Know who to refer the patients and families to.*	Don't know		Knows to refer the person to the ACP website, their GP or other healthcare providers	

Level 1 Competency: Introducing ACP, supporting pople to engage in ACP, having uncomplicated ACP conversations

Staff this is applicable to: All clinical staff with a direct caring role for patients

No	Units of competence (in addition to basic competence)	NOT MET	GETTING THERE	MET	My level
4	*Explain the benefits of ACP*	Does not know what the benefits are	Able to partially explain the benefits	Able to explain benefits to patients, families and health professionals	
5	*Discuss the underlying legal basis of ACP in general terms*	Does not know the legal status of an ACP; does not know what an EPOA is; unaware of Right 7(4)	Aware of the legal status of ACP; knows what EPOA is but unaware of how to arrange; knows what Right 7(4) is but unable to explain in general terms	Able to explain whether an ACP is legally binding and how to arrange for someone else to be able to make decisions for you if you cannot (EPoA); explains how clinicians are required to follow Right 7(4) and how ACP can improve the outcome of that process.	
6	*Discuss where ACP fits into the overall approach to care within their department or facility*	Does not know what their organisation's vision is for ACP	Has some idea of their organisation's ACP vision but unable to explain it	Able to explain what the their organisation's vision is.	
7	*Explain where ACP fits into specific procedures within their department or facility*	Does not know about their department's ACP policy or support processes	Has some idea of their department's ACP policy and support processes but unable to explain fully	Has a clear understanding of what their department's ACP policy is and what processes are in place to assist them	
8	*Explain when it would be appropriate to provide information about ACP to patients and their family*	Does not know when it would be appropriate to provide information about ACP to patients	Has some idea of when it might be appropriate to provide information about ACP but unable to be specific	Able to identify and explain opportunities for providing ACP information to patients according to departmental policy and individual need	
9	*Recognise triggers that ACP should be introduced to patients*	Unable to recognise triggers for introducing ACP to patients	Has some idea of triggers for introducing ACP to patients but unable to be specific and unable to recognise cues	Able to identify specific triggers for introducing ACP to patients including responding to cues from the patient	
10	*Initiate introduction to ACP and the basic rationale and benefits to the individual patient and/or their whanau*	Unable to introduce or explain ACP concepts to patients or whanau	Able to introduce some of the concepts and benefits of ACP to patients and/or whanau but language may not be the most appropriate for the people concerned	Able to introduce and explain ACP and its benefits to patients and/or whanau in a way that is meaningful to them	
11	*Identify how to access information about ACP*	Does not know how to access information about ACP	Has some awareness of how to access information	Can explain how to access their department's ACP policies and procedures; how to access the MoH Guidelines for Health Professionals; how to access information for the general public via the ACP website	
12	*Know when and how to refer the patient with complex needs to a person who could provide assistance with ACP*	Does not recognise when a person has complex needs or know who to refer to	Has some awareness of what might constitute complex needs; may be unsure of who best to refer to	Can recognise when a person has complex needs and knows the most appropriate person to refer to for an ACP conversation	
13	*Know how ACP documents are being stored and managed within the systems of their department or facility*	Does not know where ACP documents are stored nor processes for managing them	Knows where ACP documents are stored and has some idea about processes for maaging the documents but unable to be specific about review processes and processees for sharing ACP information	Able to explain where ACP documents are stored and how they are managed in their department or facility, including processes for review, and how and with whom ACP documents and information is shared	
14	*Acknowledge own feelings and experiences relating to end-of-life as it may impact on ACP facilitation*	Has no awareness of the fact that own feelings and experiences can potentially impact on an ACP conversation	Has an idea that own feelings and experiences can impact on an ACP conversation but unable to explain; may allow own feelings or experiences to influence the conversation	Able to explain how own feelings and experiences can impact on an ACP conversation, and how a conscious awareness of own feelings and experiences can minimise any potential negaitve impact; no evidence of feelings and experiences impacting on the conversation	
15	*Respond effectively to patients or whanau family members who request ACP discussions*	Does not know what to say, who to refer to, or how to arrange an ACP conversation	Responds with some information, and may need support to arrange an ACP conversation	Able to repond in a way that is meaningful to the person, arrange an ACP conversation with an appropriate person, and provide appropriate information	

16	***Acknowledge and respect a person's choice not to participate in ACP conversations***	Unable to recognise or accept that a patient does not want to participate in ACP	Has some idea that a patient may not want to participate in ACP and that this should be respected, but unable to demonstrate this in practice	Demonstrates sensitivity to the patient's choice not to participate in ACP, and does not attempt to manipulate a person to participate	
17	***Practice in a manner which demonstrates a willingness to be influenced by the patient's voice***	Directs the conversation according to own thoughts and ideas	Allows patient to express views and preferences but with some influence and possible reference to own views; is uncomfortable or not able to be objective when patient has different views to own	Allows the patient to express their own views and preferences without influence or coercian, even if their views and preferences differ vastly to own	
18	***Demonstrate empathy and active listening skills in facilitating the ACP conversations***	Does not demonstrate to the participant that they have heard what they are saying or feeling	Aware of what the participant is saying and perhaps has a sense of what they might be feeling but does not reflect this back to them	Demonstrates that they have heard what the participant is telling them, and reflects back to the participant that they have heard their concerns or difficulty	
19	***Clarify if there are any unresolved issues at the end of the conversation***	Unaware of the possibility of unresolved issues	Aware of potential unresolved issues but unsure how to clarify	Able to identify unresolved issues at the end of the conversation and clarify the issues, or arrange apropriate follow-up for issues to be clarified	
20	***Acknowledge emotional issues and needs of participants during the conversation***	Unaware of emotional issues and needs of participants during a conversation	Aware of emotional concerns of participants during the conversation but not sure how to manage such concerns	Aware of, and responds well to, emotional needs of participants during the conversation, including validating feelings and arranging appropriate support if necessary	
21	***Identify and explain appropriate forms of follow-up to this conversation***	Does not know how to determine that a patient should be followed up nor how this could occur	Able to determine whether the patient should be followed up but unable to explain this and/or does not know how that could occur.	Able to determine whether the patient should be followed up and directs them to their GP or other appropriate person; initiates follow up with another member of the healthcare team when appropriate	
22	***Clearly document ACP conversations, effectively capturing the patient's voice***	Does not know how or where to document conversations	Documents conversations in the health professional's words, with little evidence of the patient's voice; the patient's preferences lack clarity or are misleading	Knows where and how to accurately document the patient's values, beliefs, goals, preferences and decisions; the patient's voice is clearly evident, with the patient's own words used thoughout.	
23	***Appropriately share ACP information and completed plans***	Does not make relevant ACP information available to other members of the healthcare team	Is aware of the need to share ACP information and completed plans but is unaware of how to do this effectively	Uses local systems and processes to appropriately share ACP information and completed plans with the patient's permission; is able to guide the patient to share their ACP plan with relevant people.	
24	***Promote and advocate for an ACP approach as a routine healthcare practice.***	Does not promote ACP	Starting to introduce ACP to other clinicians within their department	Demonstrates advocacy for ACP within their department and the wider organisation, in a way that promotes a positive regard for ACP; incorporates ACP into routine practice	

Level 2 Competency: Initiate, participate in and facilitate the more complex ACP discussions and train L1s in their organisations - PROFICIENT

Staff this is applicable to: Healthcare workers looking after patients and all staff with a patient management role, including doctors, registered nurses, social workers, other allied health staff and senior personal care assistants in hospitals, community health settings and aged residential care facilities.

No	*Units of competence (in addition to basic and Level 1 competence)*	NOT MET	GETTING THERE	MET	My level
25	***Explain the legal basis underlying ACP and the difference in an advance directive, an enduring power of attorney and an advance care plan***	Unable to explain the difference between an ACP, Advance Directive and EPOA	Able to explain the legal basis for ACP but unsure of the legal differences between ACP and Advance Directive; aware that there are validity criteria for Advance Directives but unable to explain fully; is able to partially explain the legal rights of EPOA; is able to partially explain the decision-making process using ACP, Advance Directive and EPOA	Able to fully explain the legal basis of ACP and the difference between ACP and Advance Directives; able to explain what an Advance Directive is and the four criteria for validity; able to explain the legal rights and responsibilities of an EPOA ; able to explain the decision-making process for someone who has lost capacity to make decisions, including the use of Advance Directives, ACP and EPOA	
26	***Determine, acknowledge and respect the role that a person's culture may play in their approach to ACP***	Unaware of how the person's culture may impact on the ACP conversation	Has an awareness of how culture may impact on the conversation but unable to demonstrate flexibility in conducting the conversation in a way that is most meaningful and acceptable to the person	Able to explain the potential impact that a person's culture may have on an ACP conversation; demonstrates sensitivity to the cultural needs of the person, and conducts the conversation in a way that is meaningful and acceptable to the person	
27	***Utillise opportunities for ACP conversations during routine care, particularly for those individuals who may appear disinclined***	Does not recognise or use opportunities for ACP; unable to respond effectively to an individual who appears resistent	Recognises cues and opportunities for ACP conversations during clinical care but does not know how to proceed	Appropriately uses opportunities for ACP conversations during clinical care; identifies and uses patient cues to explore reluctance, and to appropriately address ACP topics whilst respecting the person's wish not to participate in ACP if that is the case	
28	***Plan and set up an ACP conversation***	Unaware of the factors to be considered when setting up an ACP conversation	Aware of the factors that need to be considered when setting up an ACP conversation; does not know how to make some of the necessary arrangements (e.g. approprpiate interpreter); unable to demonstrate flexibility in setting up the conversation in a way that is most meaningful for the person	Able to plan and set up an ACP conversation taking into account factors that will facilitate a successful conversation, such as environmental factors, provision of appropriate written material, appropriate people involved, and specific communication preferences or needs the person may have	
29	***Include in the ACP conversation any concerns the person may have and positive aspects of how they can live well in the final stages of their life***	Does not demonstrate the ability to elicit the person's concerns during the ACP conversation; unable to incorporate concepts of living well in the final stages of their life	Demonstrates some ability to elicit the person's concerns, with some acknoweldgement and empathy; tendency to want to 'fix' the person's feelings; integrates concept of living well in the last stages of their life but may have a tendency to exert their own views	Demonstrates an ability to elicit, acknowledge and empathise with the person's concerns, addressing concerns where appropriate but not attempting to 'fix' feelings; facilitates a positive regard for how they might live well in the final stages of their life, accepting the person's preferences and views	

30	***Explain conditions and treatments that may arise in end-of-life decision-making generally***	Unable to explain conditions or treatments that may arise towards the end of life	Has an awareness, in general terms, of conditions that may arise and treatments that may be available towards the end of life, but unable to explain fully	Able to explain to the person what conditions may arise and what treatments may be available towards the end of their life, in general terms; demonstrate an awareness of when further, specific, information may be required and the potential need to involve another clinician	
31	***Assist patients in framing what is important to them, their values and beliefs that may impact on the treatment choices***	Unable to elicit what is important to the person	Demonstrates an ability to begin to elicit what is important to the person; tendency to use own values and beliefs to guide the person rather than supporting them to find their own way of framing what is important to them	Demonstrates an ability to elicit what is important to the person, including their values and beliefs, and assists them in framing these things without influence or coercian	
32	***Explain conditions and treatments that may arise in end-of-life decision-making specifically with reference to the particular patient and their potential illness trajectory***	Unable to explain specific conditions or treatments that may arise as the person's disease progresses	Has some idea of the specific conditions that may arise and the specific treatments that may be available to the person, but unable to explain in a way that is meaningful to the person	Able to explain to the person what specific conditions may arise for them and the specific treatments that may be available to them, as their disease progresses including specifically at the end of their life; recognises own limitations of knowledge and involves other clinician(s) as appropriate	
33	***Assist the patient in translating what is important to them into specific treatment preferences and levels of care***	Unable to translate the person's words and concepts into statements that are meaningful to clinicians when considering specific treatment options	Demonstrates some ability to assist the person to articulate preferences for specific care and treatment; tendency to allow own preferences to influence the conversation rather than the person's expressed values and beliefs	Demonstrates an ability to assist the person to articulate preferences for specific care and treatment, underpinned by what they have expressed is important to them	
34	***Respond effectively to strong emotions that may be present during ACP conversations***	Does not respond effectively to strong emotions	Responds in a respectful way but is unable to support the person to manage their emotions and move the conversation forward	Responds to strong emotions in a way that acknowledges the person's feelings and values them as an individual, demonstrating empathy and the ability to move the conversation forward; leaves the individual in an emotionally safe place.	
35	***Assist patient and/or family to document outcomes of ACP conversations***	Unable to support the person to document outcomes from the conversation	Demonstrates an ability to support the person to document outcomes but the documentation may not accurately or completely reflect the outcomes and/or documentation is not meaningful to the person or clinicians	Demonstrates an ability to facilitate the clear documentation of the outcomes from the ACP conversation, in a way that is meaningful to both the person and to clinicians	
36	***Assist patients to discuss their care and treatment preferences with family/whanau if needed***	Unable to facilitate or support such a discussion	Facilitates a discussion between patient and family/whanau but tends to include own views and opinions, and/or allows views of family that differ from the patient to dominate	Effectively facilitates a discussion between the patient and their family/whanau in a way that feels meaningful and safe for all concerned	
37	***Takes a leadership role in promoting ACP, influencing implementation of ACP processes and ACP as part of routine healthcare practice***	Does little to promote or influence ACP beyond own practice	Promotes ACP amongst colleagues, incorporates ACP conversations into own clinical practice but does not take initiative to influence wider ACP development	Widely promotes ACP, leads initiatives to raise awareness of ACP and to promote incorporation into routine clinical practice; involved in development/review of policy and processes supporting ACP	